Statement of
Representative Charles Stcnholm
Before the Subcommittee on Health and the Environment
on
Provider Sponsored Organizations
March 19, 1997

Mr. Chairman. I commend you and your subcommittee for holding this hearing roday on the subject of provider sponsored organizations, otherwise recognized in Washington's alphabet soup as PSOs. 1 also want to commend my colleague, Jim Greenwood, for his leadership on H.R. 475, the PSO bill on which I am proud to ba lead cosponsor.

Sitting here with the subcommittee which drafted PSO language in the last Congress, associations which know every technical -- not to mention economic --jot and tittle of this market device, and providers who actually are operating this form of managed care, I assure you that this farmer comes before you with a proper sense of humility.

Through the years I have gained some experience in helping to construct health reform suggestions: one called Cooper, one called Cooper-Grandy, one called Rowland-Bilirakis, and so on. While there were variations in those proposals, there also were some common themes and goals, and it is those same goals of coat containment, access to care, and quality assurance which brought me to cosponsoring the Greenwood-Stenholm bill this year.

Through the years, my first goal has been to try to get a handle on burgeoning Medicare costs. For most of this decade, managed care has played a prominent role in that equation. I find it interesting that much of which we found unpalatable as legislated policy reform a few years ago has developed on its own within the marketplace and, indeed. coat saving has been the result.

I must immediately add critical caveats to the point just made. however. For while the market's version of managed care, unaided by government safeguards, has performed commendably on the cost side. it has shown some serious deficiencies when measured by a few other standards.

The first deficiency is spotty market penetration. The 17th District of Texas

which I am honored to represent, has a land mass about the size of South Carolina; in other words, I represent a very rural district. In my biggest city, Abilene, with a population of 110,000, there would be a 1% managed care penetration were it not for the Defense Department's TriCare program. Needless to say, managed care in most of my 30 rural counties is entirely non-existent. I understand that our government's reimbursement policies make market penetration into my District totally unreasonable from a business pcrspcctivc, but that alphabet-soup-issue, the AAPCC, is one on which I will lobby this and other committees another day.

For purposes of this hearing, my point is that PSOs are a significant piece of the puzzle to both the cost containment and the access questions. They provide cost containment in the usual managed care manner, but they are more responsive to access because PSOs rely on providers already serving in unpenetrated areas.

I have heard the argument from existing managed care companies that if they can't afford to spread into unserved areas now, these new PSOs will find it no more economically viable in the future. That argument sounds an awful lot like the one my parents heard in the '30s when large electric utility companies told them they couldn't afford to provide electricity to rural America. Interestingly enough, rural electric co-ops, supported by federal policy, proved those large companies wrong, and I believe the same can happen with PSOs today.

Another of the persistent goals of any health reform effort I've associated with has been concern about quality of care issues for Medicare beneficiaries. Here again, I'm not sure that the unguided market has done all that rational policy could and should have.

In no circumstance would WC support PSO reforms which would bring about a lessening of consumer protections. In fact, we argue strongly that beneficiaries are protected to a greater degree by our legislation. To begin with, providers who have a direct relationship with their patients will be the decision-makers about plan coverage. I don't intend to engage in insurance company bashing which is currently fashionable, but I do have a bias that looks kindly on face-to-face. community-based solutions. Under our PSO concept, clinical decisions will be in the hands of local practicing physicians, and communities will have the chance to oversee decisions which take into account the long-term health and economic needs of the community at large.

Numerous Medicare consumer protection standard9 which currently are applied to HMOs would apply to PSOs as well, but in other cases, such as utilization review and physician participation, PSOs would have to meet even further standards. In addition, the proxy for quality control, the so-called 50450 rule, would be waived only in cam where other higher quality standards are met. The bottom line overall should be a plus for consumers.

Now, I know that within the context of the general goals of cost containment, access, and quality assurance which I have outlined to this point, there are a lot of very important technical details to be worked nut, and those details will be the essence of much of the testimony you hear today. Even among people who all support the concept of PSOs, how the specific lines are drawn are of substantive and economic importance to the people filling this room.

I'm not saying that the bill Jim and I put together is perfect and shouldn't have a comma changed. We earnestly request that those who oppose portions or all of this bill offer concrete recommendations on how it might be improved while preserving the stated goals. Wc have attempted to find a reasonable middle ground on a number of tough issues.

Take solvency standards, for example. Having lived through some dreadful votes in the '80s when we picked up the pieces from a savings and loan debacle that never should have happened, I can assure you that I don't wish to create the health care equivalent. I want these organizations which claim they can provide quality, comprehensive care to be forced to show that they're up to the task, not just for a quick buck but for the long haul. That's why this bill lays out some standards which some of your witnesses today will tell you are too stringent.

Others will say the opposite, but I also reject their argument that only the current standards, only the businesses which currently are profiting from our present regulations, can safeguard the steadfastness of managed care operations. Our bill specifies explicit a9 well as general measures for fiscal soundness which reflect current HMO and insurance regulatory practices, modified to recognize the different operational characteristics of qualified PSOs.

We know that there are many legitimate questions about the solution which Jim and I have developed, and so we request the opportunity to submit for the record

several explanatory pieces about our legislation. These documents outline a summary of the bill, explain the solvency requirements included in the bill, describe differences from this bill and legislation considered in the 104th Congress, and respond to some of the most commonly asked questions asked about H.R. 475. We believe that this information will be helpful to anyone seriously studying our PSO alternative.

I want to close with a final comment not on the substance but rather the politics of our proposal. If any lesson should have been learned in recent years, first by the Democratic White House in 1993-1994 and then by the Republican Congress in 1995-1996, surely it is this: We represent a Country which longs for middle-ground, bipartisan, common sense answers to the very real challenges before us. Extremism on either pole and blind partisanship do no one, either politicians or constituents, any lasting good. Both by the bipartisan representation of this bill's cosponsors and the substantive middle-ground of its policies, we believe this is an approach Americans will endorse as they personally struggle with their own microcosm of health care cost, access, and quality issues. Both the President and Republicans endorsed the PSO concept in their budgets of the 104th Congress. This year, the so-called Blue Dog Coalition has already proposed a balanced budget which incorporates these very ideas. I urge this Committee to follow that lead and refine its PSO language in a bipartisan, middle-ground way which not only helps to meet the health care challenge but restores Americans' confidence in the process at the same time.

Thank you again, Mr. Chairman, for your courtesy in allowing my friend from Pennsylvania and I the time to speak on behalf of our PSO proposal.